

INLAND EMPIRE HEALTH PLAN
INITIAL PERINATAL RISK ASSESSMENT

DATE _____

MEMBER NAME _____

AGE _____

EDC: _____

IEHP MEMBER NUMBER _____

(Note: Medical history and anthropometric information is available on OB-Medical History forms.)
(Note: Complete Diet Recall at this time if not already completed.)

Please answer the following questions by marking a in the or by writing in the blank space

STATUS

- | | |
|--|--|
| 1. What languages do you speak? <input type="checkbox"/> English <input type="checkbox"/> Spanish Other _____ | 1. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 2. What languages do you read? <input type="checkbox"/> English <input type="checkbox"/> Spanish Other _____ | 2. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 3. How many years of school have you finished? _____ years | 3. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 4. Do you have a job? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind of work? _____ | 4. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 5. Does your partner have a job? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind of work? _____ | 5. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 6. Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are on a special diet, what kind?
Weight loss <input type="checkbox"/> low fat /low cholesterol <input type="checkbox"/> low salt <input type="checkbox"/> diabetic
Other _____ | 6. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 7. Are you a vegetarian? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, do you use milk products (milk, cheese, yogurt) and /or eggs? <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 8. Are you allergic to any foods, or do you try not to eat any foods?
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what _____ | 8. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 9. How many cups, glasses or cans of these do you drink every day?
water _____ milk _____ juice _____ diet soda _____ punch/kool aid _____
coffee _____ tea _____ soda _____ | 9. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 10. How many times a day do you usually eat (including snacks)? _____ | 10. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 11. Do you have
nausea <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
poor appetite <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No How many pounds? _____
diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
constipation <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
<input type="checkbox"/> other _____ | 11. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 12. What home remedies, food supplements, or herbs are you taking?
Ginseng <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
Ma Huang (Ephedra) <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
Manzanilla (Chamomile) <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
Hierba buena (Peppermint) <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
<input type="checkbox"/> other _____ | 12. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 13. During this pregnancy, have you eaten
maicena (cornstarch) <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
laundry starch <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
dirt or clay <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
paste or plaster <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
freezer frost <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
<input type="checkbox"/> other _____ | 13. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 14. During this pregnancy, are you taking
aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
cold medicine <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
allergy/sinus medicine <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
diet pills <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
prenatal vitamins <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
other vitamins <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
iron pills <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
<input type="checkbox"/> other _____ | 14. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |

INLAND EMPIRE HEALTH PLAN
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PROVIDER INFORMATION:

Provider Name: _____

IEHP Provider Number: _____

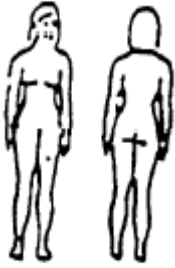
STATUS

- | | |
|---|--|
| 15. How do you plan to feed your new baby? <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both <input type="checkbox"/> not sure | 15. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 16. Have you breastfed a baby before? <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 17. a. Where are you living right now? <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Motel
<input type="checkbox"/> in a friend's house or apartment <input type="checkbox"/> Car <input type="checkbox"/> Street <input type="checkbox"/> other _____ | 17. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| How long have you lived there? _____ | |
| 18. How many people live with you?
<input type="checkbox"/> no one <input type="checkbox"/> 1-3 others <input type="checkbox"/> 4-6 others <input type="checkbox"/> 7 or more others
Who lives with you?
<input type="checkbox"/> live alone <input type="checkbox"/> husband/partner <input type="checkbox"/> parents <input type="checkbox"/> in-laws
<input type="checkbox"/> your children <input type="checkbox"/> other's children <input type="checkbox"/> friends <input type="checkbox"/> other family
How many children are in your household? _____ | 18. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 19. If you are worried about something, who do you talk to ?
<input type="checkbox"/> partner/husband <input type="checkbox"/> parents <input type="checkbox"/> grandparents <input type="checkbox"/> other relatives
<input type="checkbox"/> friend <input type="checkbox"/> other person _____ | 19. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 20. Do you have (√ <input type="checkbox"/> if yes)
<input type="checkbox"/> electricity <input type="checkbox"/> hot water <input type="checkbox"/> refrigerator <input type="checkbox"/> stove or oven
<input type="checkbox"/> transportation <input type="checkbox"/> telephone <input type="checkbox"/> heating | 20. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 21. Are you usually able to (√ <input type="checkbox"/> if yes)
<input type="checkbox"/> buy enough food <input type="checkbox"/> pay rent <input type="checkbox"/> pay other bills | 21. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 22. Have you ever had trouble finding a doctor, or getting medical help for yourself or your family? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain _____ | 22. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 23. Are you on the WIC (Women, Infants & Children) Program? <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 24. Do you have an infant car seat? <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 25. Do you use you car seat belt? <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 26. Was your pregnancy planned? <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 27. How does the baby's father feel about this pregnancy?
<input type="checkbox"/> doesn't care <input type="checkbox"/> doesn't know <input type="checkbox"/> angry <input type="checkbox"/> happy <input type="checkbox"/> sad <input type="checkbox"/> other _____ | 27. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 28. How do you feel about this pregnancy?
<input type="checkbox"/> don't care <input type="checkbox"/> angry <input type="checkbox"/> happy <input type="checkbox"/> sad <input type="checkbox"/> other _____ | 28. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 29. Have you ever had any of the following?
<input type="checkbox"/> Miscarriage <input type="checkbox"/> abortion <input type="checkbox"/> stillbirth <input type="checkbox"/> fetal demise
<input type="checkbox"/> neonatal death <input type="checkbox"/> premature birth <input type="checkbox"/> none
When did it happen? _____

What/who helped you get through this? _____ | 29. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 30. Do you have any traditional, cultural, or religious customs about pregnancy or childbirth you would like supported? <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 31. Since becoming pregnant, which of the following have you had? (√ <input type="checkbox"/> if yes)
<input type="checkbox"/> problem sleeping <input type="checkbox"/> excessive worrying <input type="checkbox"/> crying <input type="checkbox"/> depression
<input type="checkbox"/> sadness <input type="checkbox"/> none <input type="checkbox"/> other _____ | 31. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 32. Are you taking medicine for your nerves?
<input type="checkbox"/> Yes <input type="checkbox"/> No Name of Medicine _____ | 32. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 33. What two problems in your life cause you the most trouble?
1. _____ 2. _____ | 33. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 34. Have you ever thought about, planned, or tried to hurt yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 35. Have you ever thought about, planned, or tried to hurt someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 36. In the past year, have you been slapped, hit, kicked, or otherwise physically hurt be someone?
<input type="checkbox"/> Yes <input type="checkbox"/> No
By whom? (Check all that apply)
<input type="checkbox"/> partner/husband <input type="checkbox"/> ex-husband <input type="checkbox"/> parent
<input type="checkbox"/> step-parent <input type="checkbox"/> stranger <input type="checkbox"/> brother/sister | 36. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |

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other _____ # times hurt _____



STATUS

37. On this picture mark the area of the body where you have been hurt. 37. L M H
38. For how many months or years have you been hurt by this person? _____
 Not applicable 38. L M H
39. How many cigarettes do you smoke each day?
 don't smoke less than 1/2 pack 1/2 pack 1/2 to 1 pack
 1-2 packs 2-3 packs more than 3 packs 39. L M H
40. Do you live with anyone who smokes? Yes No 40. L M H
41. Check all that apply:
 a. Does the father of your baby use drugs or drink alcohol? Yes No
 Do/did your parents use drugs or drink alcohol? Yes No
 Do/did you have friends who use drugs or drink alcohol? Yes No
 b. What drugs did you use before this pregnancy? 41b. L M H
 cocaine marijuana speed, methamphetamines PCP
 heroin none other _____
 c. How often do you drink beer, wine, or liquor?
 daily weekends 1-2 times a month rarely or never
 Have your alcohol habits changed since you became pregnant?
 Yes No If yes, how? _____ 41c. L M H
42. Have you received counseling on HIV (AIDS) in pregnancy? Yes No 42. L M H
43. Tell us what you know about and want to learn about:

Already Know <input type="checkbox"/> Child Care <input type="checkbox"/> Hospital Tour <input type="checkbox"/> Labor & Delivery <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Circumcision <input type="checkbox"/> Substance Abuse <input type="checkbox"/> How Your Baby Grows <input type="checkbox"/> Making Children Behave <input type="checkbox"/> Car Seat Safety <input type="checkbox"/> Signs of Preterm Labor	Already Like to Know <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Infant Feeding <input type="checkbox"/> Baby Care <input type="checkbox"/> Exercise <input type="checkbox"/> Stop Smoking <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Body Changes During Pregnancy <input type="checkbox"/> Other _____
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43. L M H
44. a. How do you learn new things best? (Please check all that apply) 44a. L M H
 _____ read _____ watch video _____ talk one-to-one
 _____ go to class _____ Pictures or diagrams _____ Demonstration
 Other _____
- b. Do you have any problems with hearing, seeing, or depression that will make it hard for you to learn new things? Yes No 44b. L M H
 If yes, please explain _____
45. a. Will you have any problems coming to prenatal classes? Yes No 45a. L M H
 H If yes, please explain _____
- b. Who can come to prenatal classes with you? _____ 45b. L M H
 things (goals) you would like to work on during this pregnancy.
46. List one or two things (goals) you would like to work on during this pregnancy 46. L M H
 1. _____
 2. _____

Perinatal Risk Assessment Form (English)

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If patient assisted by staff to complete assessment tool
Assessment Tool Completed by:

Name _____ Title _____ Date _____

Assessment Reviewed by:

Name (OB) _____ Title _____ Date _____

Name (H.E.) _____ Title _____ Date _____

Name (Nut.) _____ Title _____ Date _____

Name (Psych. Soc.) _____ Title _____ Date _____

2nd Trimester reassessment completed by:

Name (OB) _____ Title _____ Date _____

Name (H.E.) _____ Title _____ Date _____

Name (Nut.) _____ Title _____ Date _____

Name (Psych. Soc.) _____ Title _____ Date _____

3rd Trimester assessment completed by:

Name (OB) _____ Title _____ Date _____

Name (H.E.) _____ Title _____ Date _____

Name (Nut.) _____ Title _____ Date _____

Name (Psych. Soc.) _____ Title _____ Date _____

Postpartum assessment completed by:

Name (OB) _____ Title _____ Date _____

Name (H.E.) _____ Title _____ Date _____

Name (Nut.) _____ Title _____ Date _____

Name (Psych. Soc.) _____ Title _____ Date _____

Copy Permission:

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